PRESENT STATUS AND PROBLEMS OF NEW YORK CITY'S COMPREHENSIVE NEIGHBORHOOD FAMILY CARE HEALTH CENTERS*

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IN the spring of 1966 the New York City Department of Health for the first time began to venture actively into the field of medical care. For some time there had been isolated discussions of the futility of separating preventive and curative medicine. This problem was understood by the public—at least by the segment of the public that used the health centers. These people could not understand why a baby who was well should see a doctor when the same doctor, on seeing the child when it was ill, could not prescribe corrective measures for the illness; nor why, if a Health Department clinic diagnosed diabetes, it would have to send the patient to a hospital to be put on a diet or to be advised on the use of insulin. Not only was it hard for the patient to understand, but it was difficult for the professional public health staff to explain and defend this system.

During the preparation of the capital budget request of 1967-1968 it was decided to convert the health centers into preventive and therapeutic facilities where the physical condition and size of the building would permit this. Eight such health center sites were selected in poverty areas; the cost of renovation was included in the capital budget request, and funds were also requested for the construction of six new centers. The review of the program for neighborhood-based family care by the city administration was extremely enthusiastic; the Health Department was granted planning funds for seven new family health centers (so-called free standing clinics) and for nine renovations for existing health centers. All capital costs would be borne by the city.

This so-called ambulatory care plan, or neighborhood health care

*Presented in a panel, Group Practice in Comprehensive Health Care Centers, as part of The 1968 Health Conference of The New York Academy of Medicine, *Group Practice: Problems and Perspectives,* held at the Academy, April 25 and 26, 1968.

center plan, was conceived to be self-financing after the first year or two of operation. It was thought that seed money would be granted by the Department of Health for the length of time necessary to carry the programs, and for service fees. From that time on no more special funds would have to be allocated. As described, the program is based on the comprehensive neighborhood-based family clinic where all members, regardless of age or income, could receive care and where the preventive and therapeutic aspects of medicine would be integrated. The program is planned on the concept of the family doctor, and it is expected that 80 per cent of family illnesses will be taken care of at this level. The components of care will be general medicine, pediatrics, obstetrics and gynecology, mental health, and dentistry. Small laboratories are provided for the analysis of urine and for blood counts. Roentgen examinations of the chest and long bones are made. A prepackaged pharmacy is also included. Specialist services and inpatient care will be provided at the hospital involved. Ideally, home care should be a component of the program. It is possible by means of this plan to phase out Health Department clinics.

Staffing for these centers is to be provided by the supporting hospital, which will agree by contract to provide specific service. The financing of the program was discussed previously. The hospital will take responsibility for the total care of the patient, and a unit record of the hospital and ambulatory care center will be used. It need not be said that the program would mandate such things as 24-hour coverage, appointment systems, evening hours, and transportation systems. In reality the program, instead of being hospital-based, is the reverse: the hospital is the satellite of the neighborhood.

To date we are planning the renovation of 12 health centers. Some of the renovations originally planned have had to be dropped because, on architectural review, the buildings proved to be either inadequate or too expensive to alter. The Health Department presently plans 16 free-standing centers. A model center plan has evolved which can compete with the best physical settings provided in private medicine. In addition to the seven provided for in last year's budget, there is every indication that we shall receive at least three more free-standing centers in this year's capital budget. It is hoped that the program will eventually care for about one million persons by means of a capital investment of about $100 million in five years.

With this cursory review of the program, let me review rapidly the planning and implementation that is going on, and our many frustrations.

Community Participation

As part of the planning of the program, the Health Department actively seeks the advice of the community on two levels. One is through the Community Advisory Committee on Ambulatory Care to the Commissioner of Health. This committee is composed of city-wide community agencies and some local community representatives, and it acts as a sounding board for major policy decisions and as a two-way communication mechanism between the community and the department.

The second part of community involvement is at the local level. We actively seek out community advice and support of the site for the new units except in unusual circumstances such as the availability of city-owned property in the area. After approval by the community, the location is recommended to the Site Selection Board for the usual city procedure. Once again we sit down with the community and the supporting hospital to work out details of the program with the guidelines given as listed previously. At this point the special needs of the community and area are taken into consideration for the program. In all cases the day-to-day operation of the center is under a Joint Policy Committee with equal representation between the hospital and the community and one member from the Department of Health.

Despite the ideal of complete community involvement, it has often been difficult for us to find if all the community has been involved. Factionalism within a locality sometimes prevents this and makes clear understanding and agreement on plans impossible. However, in some localities we are doing very well.

Contracts

It has also been difficult to have the contracts for service accepted—whether they have included city funds or not. Many agencies and officials must be satisfied with the contract: the hospital, the Health Department, the community, the corporation counsel, and the comptroller. Each sees the proposal from its own vantage point. One contract, after six months, is still in process of completion. Negotiation is particularly difficult if the federal government is also a cooperating party (e.g., the Office of Economic Organization).

Construction

The problem of construction of health facilities has been adequately documented both in the Piel Report and in the mayor's announcement of his desire for a Health Facilities Construction Authority. To illustrate causes for some delays here are a few examples: to make a few renovations in a health center which is in good condition takes one and one-half years; to put up a new building on readily available land, two and one-half to three years; and if land must be acquired, five years. How can enthusiasm for a program be maintained when members that plan a facility may not even be on the staff when the center is finally ready to operate? In addition, how can a hospital give a commitment on staff for a program five years or more in the future?

Staff

The problem of staffing these centers is a real one. Every center designed to care for 55,000 persons needs at least 16 full-time internists and 14 pediatricians, 1½ full-time public health nurses, 10½ nurses' aides, 5 social workers, and 10 clerks. For the program to date we shall need at least 530 doctors if we do not change the usual method of delivery of care. Everyone speaks of new kinds of personnel, assistant doctors, aides, nurses, pediatricians, etc., but just how many agencies are training this type of personnel? Talk is not enough now. We have very little lead time. Some ambulatory care units are already handicapped because of their inability to recruit. Are we not compounding the problem, or will the new family aide and other such personnel be able to take a good share of the burden from the doctor? Are the doctors willing to allow nurses or other trained persons to take care of healthy babies? Where are the assistant doctors everyone is talking about training? Who is ready to do this training? What about changes in the State Education Law needed to allow such practice? Are we tooling up fast enough to automate the routine physical examination that we have been advocating for years?

Funding

Next we must consider our funding problem—it should be called a funding catastrophe. This entire ambulatory program was conceived on a five-year basis, and plans are well on their way—plans based on Medicaid, a reimbursement method which has changed its rules so

drastically as to leave the Health Department's ambulatory care program in a quandary. How can you give family-based care when the state Medicaid law exempts adults 21 to 64 years of age from care? It is deplorable that 100,000 persons in need were cut from the program, but it is much more unfortunate that families can no longer be cared for as a unit. It has been stated that these adults will pay for care. Experience in the New York City outpatient system has shown they do not and that most cannot. Many assert that the city will pick up the bill. The departments of the city have been told they cannot—everyone knows the city is in serious financial difficulty. What then—are these persons now to await serious illness, thence to visit the Emergency Room in the middle of the night? Why embark on a major capital-investment program when we cannot fund the programs that are ready to operate?

How can anyone plan a good long-range program on the quicksand of current financing practices? How can we afford the luxury of categorical grants for superb care for a few while so many need just adequate care, given in a humane manner in comfortable surroundings?

Standards

Another problem is one that cuts across the total ambulatory care picture in the state—that of the setting of standards, auditing, and enforcement. For the past year many technical committees of the Health Department have been working to set standards for ambulatory care in pediatrics, maternal and newborn services, adult health, nursing, social work, podiatry, and many others. Yet according to the state we do not have the authority to do so either under the Folsom Act or the Medicaid Law. The state is willing to accept some of our recommendations and incorporate them into the state program. Not being able to set the policy, how can we enforce it? At present the state audits all health programs in New York City except those in proprietary hospitals. Is it not duplicating activity for both of us to work on this? Should not the city Health Department be delegated this responsibility—and not just for the Medicaid program but for auditing the total health care of the city? What is happening to home rule in health?

The department has been working closely with the Association of Directors of Ambulatory Care of the city with the aim of developing

a practical approach to standards of ambulatory care. We are awaiting a legal opinion on our role.

To evaluate programs adequately, the Office of Program Planning and Research of the Health Services Administration has been working with many hospitals and ambulatory care units to try to create a city-wide unit record system so that all programs and results may be compared. It is hoped that a uniform system of reporting will evolve. In addition, evaluation or auditing systems and teams are being set up. The real problems here seem to be: Are our utopian standards achievable as written? Will the state allow us to use them? And, lastly, who shall audit health care in the city?

In the past we have had some difficulty with labor unions. Most of our Health Department physicians are members of unions. When we convert our health centers to include treatment hospital personnel will be working side by side with Health Department personnel—with salaries, vacations, and sick allowances, and working hours that differ. This does not make for the best personnel relations. Some hospitals are insisting that they provide the total staff for the Health Department and ambulatory care programs. We have assured the union there will be no loss of jobs by Health Department personnel. For a short time we shall be able to transfer staff to areas where there are vacancies, but this cannot continue for long.

The New York City program is unique primarily because of its magnitude—great both in the numbers of people needing service, and the scope of the program envisioned to fill the need. Indeed it is often frustrating but, as Mitchell I. Ginsberg has said, it is time to face up to the problem of providing adequate health care for all. Our department still suffers from the high hopes of achieving this, as we all do; otherwise we should not be here now.